DATA

**Family Questionnaire**

**Child's Name:** _____ **Your Name:** _____ **Relationship:** _____

**Note to Parents/Guardians:**

*Welcome to DATA and THANK YOU for investing your valuable time and input into your child's care. Nobody has known a child longer than his/her family. Please complete the following questions to the best of your ability. This questionnaire will assist the staff in planning appropriate treatment goals with you and your child. Please feel free to add any additional information that you think may be helpful to know that was not asked in these standard questions. If at any time you have questions, please notify your child's therapist or any DATA staff member.*

## PRESENTING PROBLEM

What event happened to bring your child to DATA? Why now? _____

_____

How do you think your child feels about coming to DATA? _____

_____

_____

Does your child say/believe they have a problem with alcohol and/or drugs? ☐ Yes ☐ No

Do you believe your child has a problem with alcohol and/or drugs? ☐ Yes ☐ No

Family support is a very important part of helping your child become and remain drug and alcohol free. Are you willing to fully participate in the family portion of treatment? ☐ Yes ☐ No

- If you are not willing to participate in treatment with your child, please share why: _____

  _____

## SUBSTANCE USE HISTORY

Has your child ever received treatment for substance use? ☐ Yes ☐ No

- If you answered YES to the questions above, please complete the following box:

| Name of Program | Type of Program | When | How was it? |
|---|---|---|---|
| | ☐ Outpatient<br>☐ Residential<br>☐ Other | | |
| | ☐ Outpatient<br>☐ Residential<br>☐ Other | | |
| | ☐ Outpatient<br>☐ Residential<br>☐ Other | | |

If your child is using drugs, please complete the chart below. ☐ My child is not and has not used drugs.

| Drug *(Including Alcohol)* | How Often Do They Use | How Much Do They Use | Age at First Use |
|---|---|---|---|
| | | | |
| | | | |

What problems have resulted from your child's use? _____

_____

_____

What MEDICAL problems is your child exhibiting as a result of their drug use: _____

_____

Describe how your child's behavior has changed since they started using drugs/alcohol: _____

_____

_____

Does anyone else in the family use drugs/alcohol? If so, please explain: _____

_____

_____

## SOCIAL BACKGROUND

How do you describe your child: _____

_____

_____

How many of your child's friends use alcohol/drugs? ☐ All ☐ Most ☐ Some ☐ None ☐ I don't know

Do you approve of your child's friends? ☐ All ☐ Most ☐ Some ☐ None

Do you foresee any problems with your child interacting with other youth while here in treatment? ☐ No ☐ Yes

- If Yes, please explain: _____

  _____

How does your child spend their free time: _____

What activities does your child enjoy: _____

Does your child have a boyfriend or girlfriend: ☐ Yes ☐ No

- If YES, do you approve of their boyfriend or girlfriend: ☐ Yes ☐ No

Is your child sexually active: ☐ Yes ☐ No ☐ I Don't Know

## FAMILY BACKGROUND

Who all lives in the home with your child? _____

_____

_____

_____

Is there anyone who is involved in your child's life living outside the home? _____

_____

_____

How would you describe your home environment? _____

_____

_____

To your knowledge, has your child ever experienced:

☐ Physical Abuse ☐ Mental Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Never been abused

- If YES, please explain:_____

  _____

Has the DCF ever been involved in your family's life? ☐ No ☐ Yes *(Past)* ☐ Yes *(Current)*

- If YES, please explain: _____

  _____

## EDUCATIONAL/VOCATIONAL BACKGROUND

Is your child currently enrolled in school: ☐ No ☐ Yes *(If YES, please complete the following box)*

| School Name | | Current Grade | |
|---|---|---|---|
| Average Grades | ☐ A ☐ B ☐ C ☐ D ☐ F ☐ Don't Know | | |
| Literacy Level | ☐ Great ☐ Average ☐ Below Average ☐ Don't Know | | |

Has your child ever been suspended or expelled: ☐ Suspended ☐ Expelled ☐ Neither

Does your child have any learning disabilities or special needs: ☐ No ☐ Yes

- If YES, please explain: _____

What subjects does your child enjoy or excel at: _____

What subjects are difficult for your child: _____

What are your child's goals for after high school: _____

## LEGAL HISTORY

What <u>CURRENT</u> legal problems does your child have: _____

What PAST legal problems has your child had: _____

Were PAST problems a result of drug/alcohol use: ☐ No ☐ Yes

- If YES, please explain: _____

_____

## PSYCHIATRIC/MENTAL HEALTH BACKGROUND

Has your child ever received psychiatric or mental health services?
☐ Never Received ☐ Yes *(If Yes, complete table below)*:

| When | Duration | Agency | Type of Treatment | Treatment Effectiveness |
|---|---|---|---|---|
| | | | | ☐ Not Effective<br>☐ Somewhat<br>☐ Very Effective |
| | | | | ☐ Not Effective<br>☐ Somewhat<br>☐ Very Effective |
| | | | | ☐ Not Effective<br>☐ Somewhat<br>☐ Very Effective |

Has your child ever been prescribed psychiatric medications?
☐ Never Taken Medication ☐ Yes *(If Yes, complete table below)*:

| Medication Name | Dose | Current/Past Use | Condition/Problem | Treatment Effectiveness |
|---|---|---|---|---|
| | | ☐ Current<br>☐ Past | | ☐ Not Effective<br>☐ Somewhat<br>☐ Very Effective |
| | | ☐ Current<br>☐ Past | | ☐ Not Effective<br>☐ Somewhat<br>☐ Very Effective |

Has your child ever attempted suicide?
☐ No ☐ Yes *(If Yes, complete box below)*:

| Date(s) Attempted | Method Attempted | Intoxicated At Time of Attempt | Treatment Provided |
|---|---|---|---|
| | | ☐ Yes ☐ No | |
| | | ☐ Yes ☐ No | |

Has your child ever exhibited signs of an eating disorder: ☐ No ☐ Yes *(Past)* ☐ Yes *(Current)*

How does your child express their feelings: _____

_____

How do you think your child feels about themselves: _____

_____

What are you child's strengths: _____

_____

What motivates your child: _____

_____

What else should know about your child or your family? _____

_____

_____

_____

May we share the information you have provided with your child: ☐ Yes ☐ No

Would you like to meet with your child's therapist to discuss any of the information provided on this questionnaire or anything else that may assist us with your child's treatment: ☐ Yes ☐ No

_____ _____

Parent/Legal Guardian Signature Date

*Therapist Section Only*

*I have reviewed this questionnaire and discussed any observations or concerns with the youth's parent or legal guardian.*

_____ _____

Therapist Signature/Credentials Date

DATA

Behavioral Health Services
for Children and Families